

Malaria

Malaria is a Class B Disease and must be reported to the state within one business day.

Background

Malaria is caused by a protozoan parasite that is transmitted by Anopheles mosquitoes. There are five species of malaria parasite: *Plasmodium falciparum*, *P.vivax*, *P.ovale*, *P.malariae*, and *P.knowlesi*. The fifth species, *P.knowlesi*, a simian malaria parasite, has recently been observed transmitting malaria to humans in Southeast Asia. It was discovered in Malaysia; several human cases have also been reported in Thailand, Myanmar, and the Philippines.

Malaria is transmitted to humans through the bite of an infective mosquito who has previously taken a blood meal from an infected human. Therefore, people usually only become infected with malaria if they live in or travel to countries where there is regular malaria transmission. Transmission also occurs rarely through blood transfusions and congenitally (infected mothers infecting their child during pregnancy).

Symptoms usually begin ten days to four weeks after infection; two malaria species, *P.vivax* and *P.ovale*, can cause relapses. Symptoms commonly include fever and flu-like illness (chills, headache, muscle aches, and tiredness), and can also include nausea, vomiting, diarrhea, anemia and jaundice. If left untreated, malaria can cause kidney failure, seizures, mental confusion, coma, and death. There are several antimalarial drugs available that should be taken early on in the course of illness.

History

In the late 19th Century, approximately half of the United States was endemic with malaria. At the turn of the 20th Century, when the prevalence of malaria was approximately 350 cases per 100,000, the U.S. Public Health Service established improved protocols to control and reduce the spread of malaria. In 1933, the U.S. Tennessee Valley Authority bill was signed to improve and develop the land and waterways in the Tennessee River valley region, where 30% of the population was affected by malaria. The bill led to the creation of a malaria control program which reduced mosquito breeding sites and utilized insecticide applications.

In 1939, Dichloro-diphenyl-trichloroethane (DDT) was discovered and, by the end of WWII, was being used for malaria control. In 1942, the Malaria Control in War Areas (MCWA) was established to control malaria around military bases in the southern U.S. and its territories. In 1947, the National Malaria Eradication Program (NMER) was created as a cooperative effort with state and local health agencies of 13 southeastern states and the Centers for Disease Control and Prevention (CDC), whose efforts consisted primarily of house-spray applications. Malaria was successfully eradicated in the U.S. in 1951.

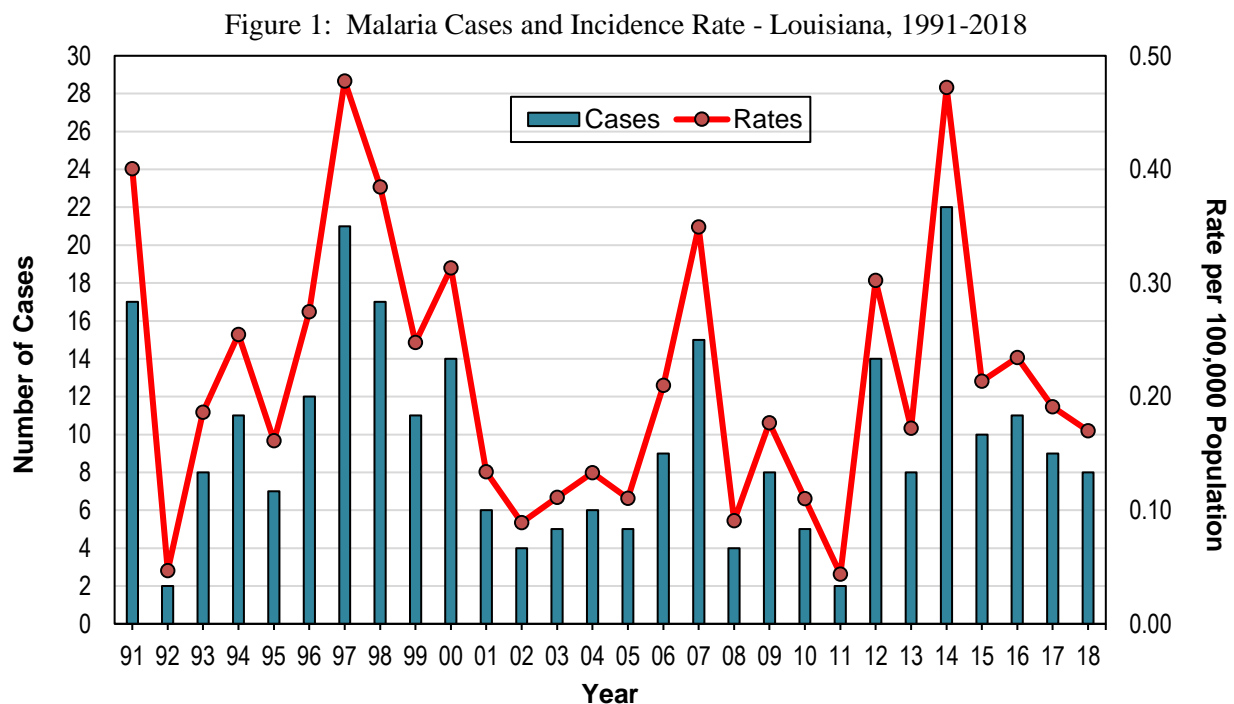
Almost all of the cases of malaria that have been reported since its eradication were imported from overseas travel or immigrants. In the 1940s, Louisiana had a peak case rate of 57 cases per 100,000, (reported in 1944). In 1947, after the initiation of the NMER, the case rate reduced to eight cases per 100,000, and was further reduced to 0.2 cases per 100,000 four years later. In the early 1950s, there was another peak of malaria cases secondary to the Korean War, with 18 cases per 100,000 (reported in 1952). With the exception of small rises in cases during times of war (Vietnam - 1967-71; Gulf War - 1990), Louisiana maintains strict malarial control.

The epidemiologic picture of malaria in Louisiana is that of an imported disease. It reflects the pattern of travel from malarious areas as described below. Therefore, it would be expected to observe peaks and troughs following the arrivals of:

- Immigrations and refugees
- Military campaigns
- Business trips
- Foreign students
- Tourists

Incidence in Louisiana

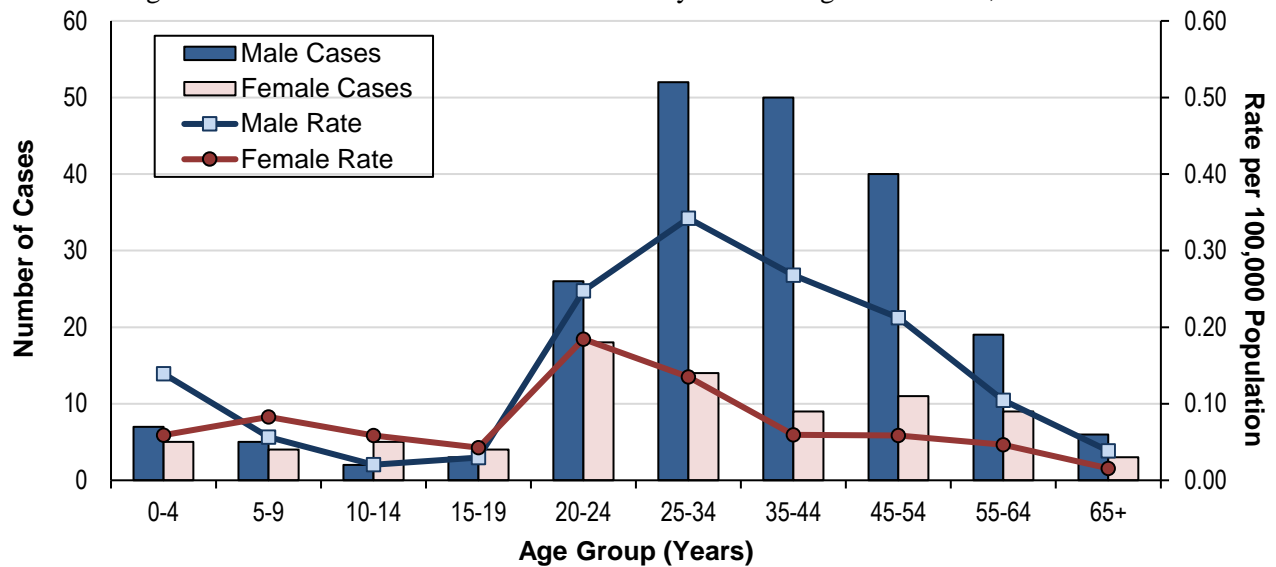
In 2018, there were eight cases of malaria reported in Louisiana, which is similar to the average over the past 20 years of 9.2 cases. The incidence rate in 2018 was 0.17 per 100,000 population, which is similar to the 20-year average incidence rate of 0.20 per 100,000 population (Figure 1).



Incidence Rates by Sex and Age

For the period from 1991 to 2018, there was an average of 6.7 cases per year for males and 2.9 cases per year for females. The average incidence rate for males was 0.31 cases per 100,000 population and 0.13 cases per 100,000 population for females; the rate ratio for males to females is 2.32. The majority of the malaria cases were adult males (range 25 to 64 years of age). Among the females, the majority of the cases were young adults aged 20 to 34 years (Figure 2).

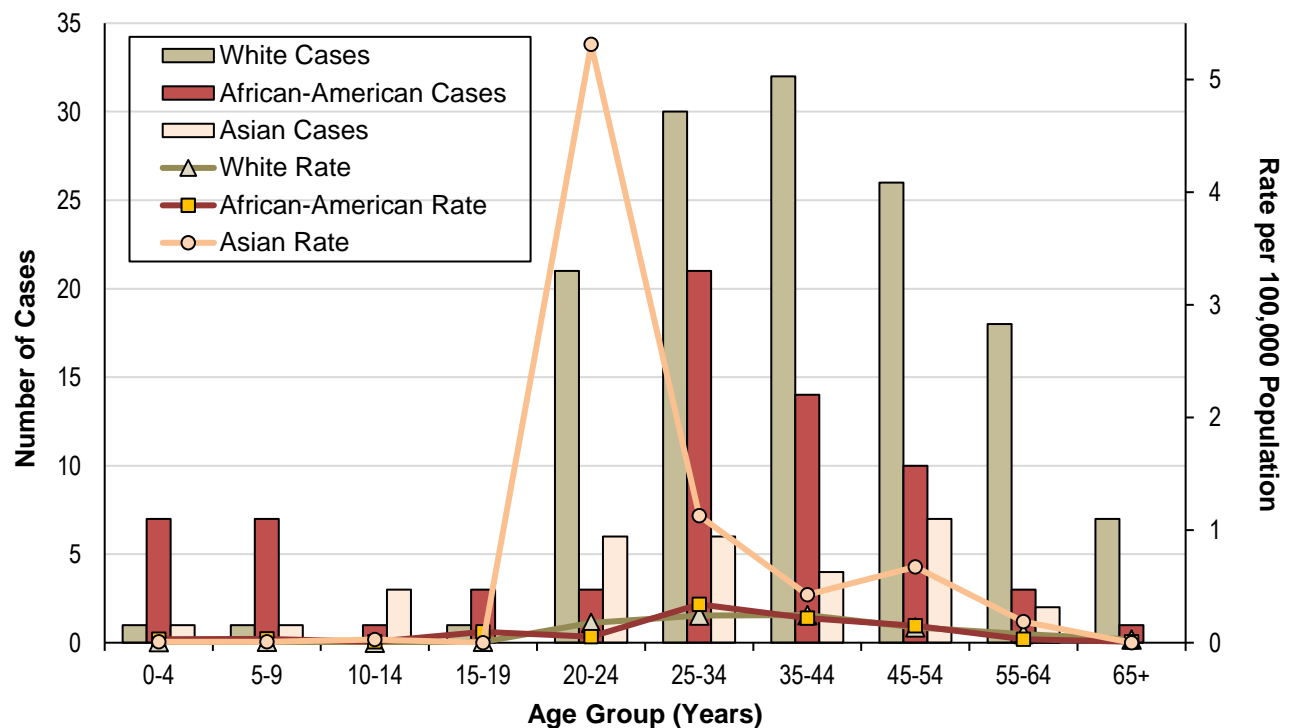
Figure 2: Malaria Cases and Incidence Rates by Sex and Age - Louisiana, 1991-2018



Incidence Rates by Race and Age

For the period from 1987 to 2018, there was an average of 4.6 cases per year for Whites, 2.4 cases per year for African-Americans, and one case per year for Asians. The majority of cases occurred among Whites, ages 20 to 64 years; however, if the population size for each group was considered, Asians had a much higher incidence rate than the other two groups in the age groups from 20-64 years of age, with the highest incidence in the 20-24 year age group.

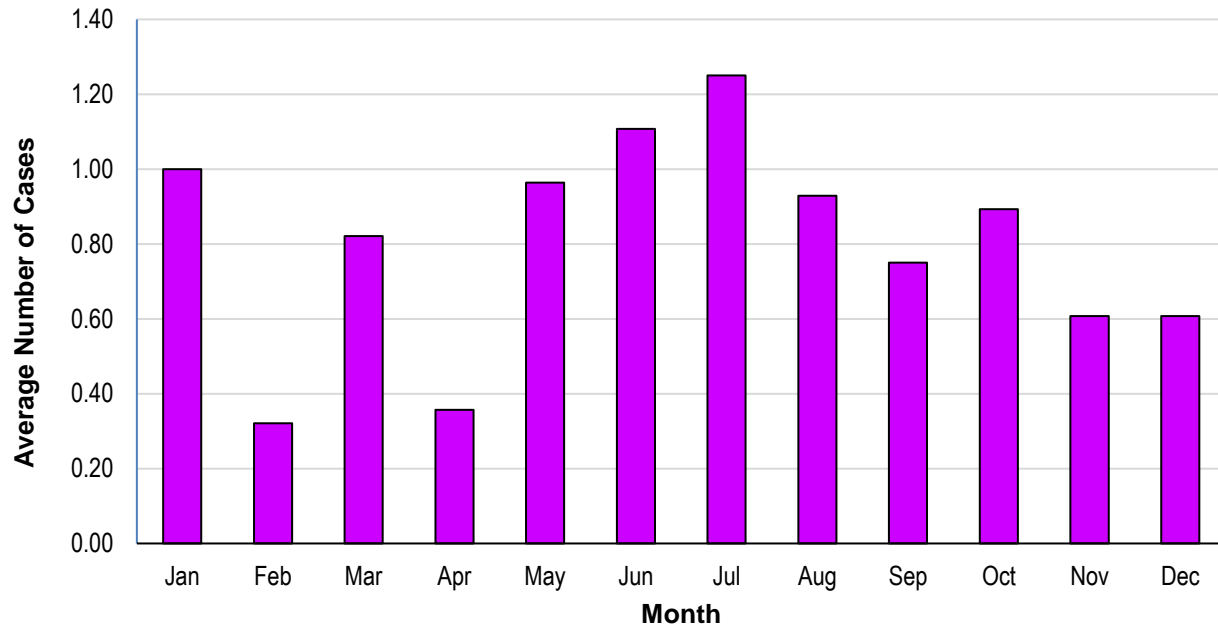
Figure 3: Malaria Cases and Incidence Rate by Race and Age - Louisiana, 1987-2018



Malaria Cases by Month

The seasonal distribution of malaria over the past 26 years reveals a three-month peak from May to July (Ratchet circular scan test for seasonal peak, $p < 0.005$). The fewest cases occur in February and April (Figure 4).

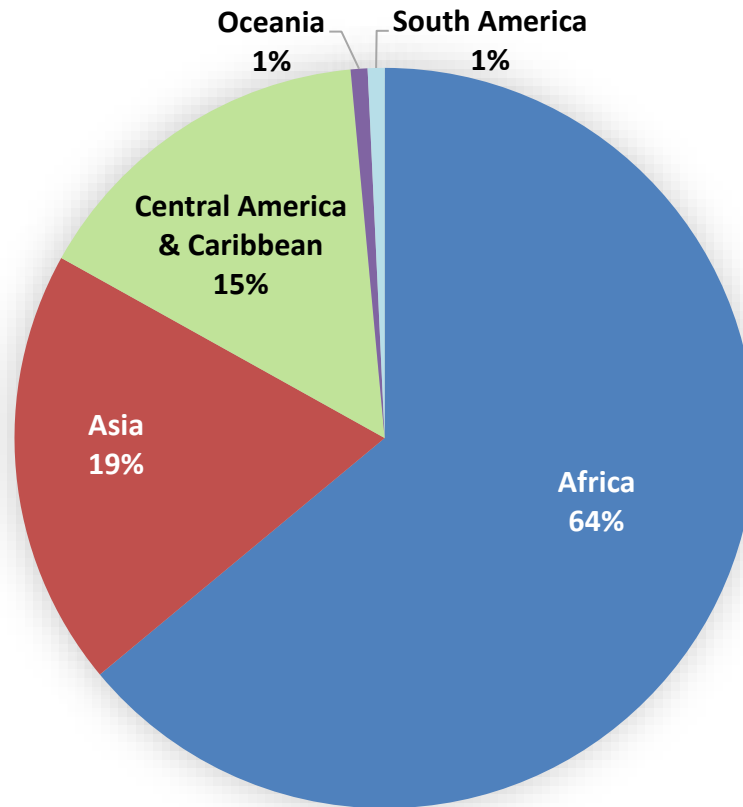
Figure 4: Average Malaria Cases by Month - Louisiana, 1991-2018



Travel Locations

All reported cases of malaria were acquired outside of the United States. The majority of malaria cases (64%) reported travel to Africa prior to illness, followed by 19% reporting travel to Asia and 15% reporting travel to Central America and the Caribbean. Only a few cases reported traveling to Oceania or South America (Figure 5).

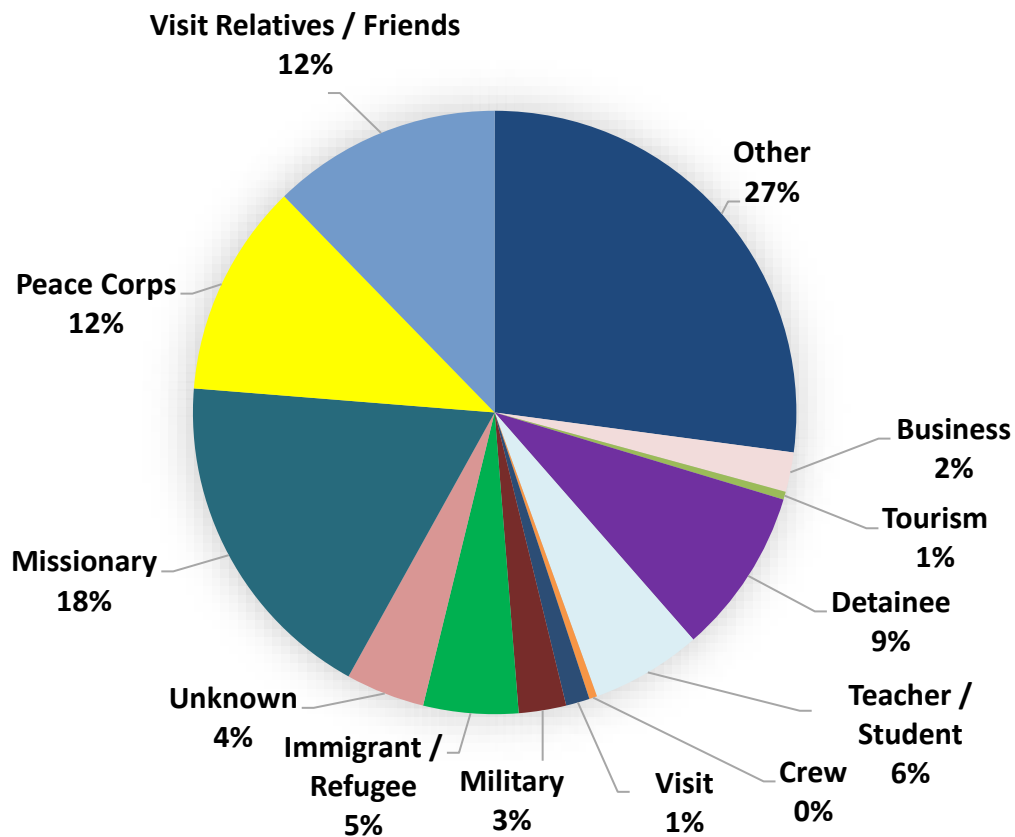
Figure 5: Malaria Cases Travel Locations Prior to Illness - Louisiana, 1999-2018



Reason for Travel

The most common reasons for travel reported by malaria cases from 1992 to 2018 were: business (27%); unknown (18%); visit (11%); and visiting friends and relatives (12%). Fewer cases reported being a tourist, missionary, teacher or student, Peace Corps volunteer, refugee, or detainee as reasons for travel (Figure 6).

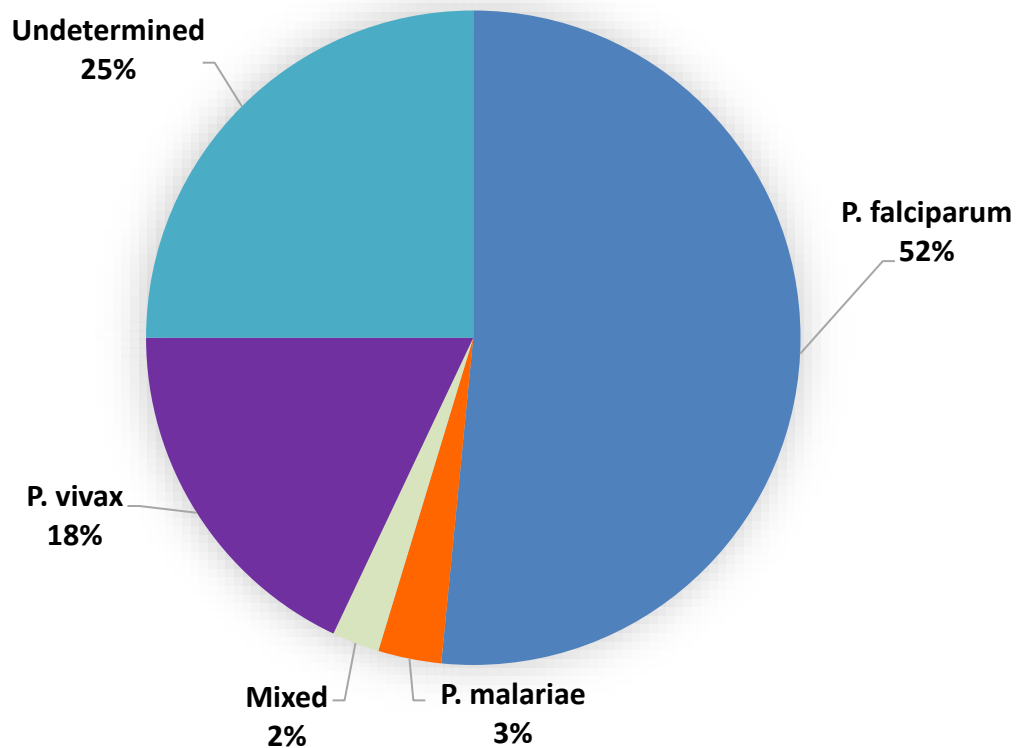
Figure 6: Malaria Cases Reason for Travel – Louisiana, 1992-2018



***Plasmodium* Species**

The majority of reported malaria cases were infected with *P.falciparum* (52%), followed by *P.vivax* (18%), and *P.malariae* (3%). Species were undetermined in 25% of malaria cases, and mixed species were reported in 2% of cases (Figure 7).

Figure 7: *Plasmodium* Species – Louisiana, 2001-2018



Mortality

Only two deaths were reported among malaria cases from 2001 to 2018, one in 2003 and one in 2017.

Prevention

Due to the resurgence of malaria during the past decade, travelers to malarious areas need to protect themselves against acquiring infection. Preventing mosquito bites by using insect repellent and bed nets, as well as preventing malaria infection through the use of chemo-prophylaxis are both preventive measures. The traveler's risk of acquiring malaria in areas to be visited determines the appropriate prevention regimen. Anti-malarial drugs are often highly important in preventing malaria infection; however, failure of prophylaxis may occur for numerous reasons:

- 1) Travelers may not seek or follow advice or may receive inaccurate advice regarding anti-malarial medication.
- 2) Travelers may forget to use prophylaxis, may not completely understand chemo-prophylactic advice, or may be advised by peers not to use chemoprophylaxis.
- 3) Persons who visit friends or relatives living in areas with endemic malaria often are less likely than other tourists to obtain pre-travel advice to use chemoprophylaxis.
- 4) Many physicians infrequently provide pre-travel advice to patients, and may not be aware of the current recommendations.
- 5) Travelers may have side effects from the chemoprophylaxis regimen prescribed for them, so they discontinue their regimen while in malarious endemic regions.

Anti-malarial Resistance

In recent years, cases of malaria resistant to atovaquone-proguanil, one of the leading treatments for uncomplicated malaria, have been observed, including two cases in Louisiana. Both cases were infected with *Plasmodium falciparum*, both stayed in the same location in Nigeria, and both experienced treatment failure due to this drug resistance. The samples from these patients were shown to be genetically distinct, indicating that such resistance develops independently in various individuals.